

SPECIMEN SUBMISSION FORM
STATE LABORATORY INSTITUTE
305 SOUTH STREET, JAMAICA PLAIN, MA 02130-3597
Phone 617-983-6200

**Do Not Use
This Space**

PRINT, APPLY LABEL OR STAMP: DO NOT ABBREVIATE

ONLY ONE TEST PER SUBMISSION FORM

Send Results To: Facility / Laboratory Name <i>(required)</i> Address Phone # Ordering Provider and Phone #	Patient Information: Last Name, First Name, MI Address Patient ID Phone # Sex: M F Other Date of Birth: Race: (Check One) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><input type="checkbox"/> American Indian or Alaska Native</td> <td style="width: 50%;"><input type="checkbox"/> Asian</td> </tr> <tr> <td><input type="checkbox"/> Black or African American</td> <td><input type="checkbox"/> White</td> </tr> <tr> <td><input type="checkbox"/> Native Hawaiian or Pacific Islander</td> <td><input type="checkbox"/> Other</td> </tr> </table> Ethnicity: Hispanic or Latino Non-Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian						
<input type="checkbox"/> Black or African American	<input type="checkbox"/> White						
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other						

Test Requested: _____
(required) One Per Form

Collection Date: _____
(required) One Per Form

Serology			
<input type="checkbox"/>	Acute	<input type="checkbox"/>	Contact
<input type="checkbox"/>	Confirmation	<input type="checkbox"/>	Surveillance
<input type="checkbox"/>	Convalescent	<input type="checkbox"/>	Symptomatic

Culture
Date of Culture:
Date of Subculture:
Sample Treated Y N If yes, how:

Source of Specimen: (required) One Per Form

<input type="checkbox"/>	Anal canal	<input type="checkbox"/>	Nasopharynx	<input type="checkbox"/>	Stool	<input type="checkbox"/>	Body Fluid (site)
<input type="checkbox"/>	Blood	<input type="checkbox"/>	Plasma	<input type="checkbox"/>	Throat (pharynx)	<input type="checkbox"/>	Bronchus (site)
<input type="checkbox"/>	Bone Marrow	<input type="checkbox"/>	Serum	<input type="checkbox"/>	Urethra	<input type="checkbox"/>	Exudates (site)
<input type="checkbox"/>	Cervix	<input type="checkbox"/>	Spinal Fluid	<input type="checkbox"/>	Urine	<input type="checkbox"/>	Wound (site)
<input type="checkbox"/>	Gastric	<input type="checkbox"/>	Sputum	<input type="checkbox"/>		<input type="checkbox"/>	Tissue (site)
<input type="checkbox"/>	Other: (Specify)						

Additional Patient Information:

Symptoms, Date of Onset, and Duration
Travel History (Dates and Locations)
Animal / Insect contact: (specify)
Relevant Immunizations (Dates)
Previous Laboratory Results
Additional Information

For information on testing, see **Manual of Laboratory Tests and Services:** <http://www.mass.gov>
SS-SLI-1-08

Search: manual lab

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Please fill out “Additional Patient Information” section on front of form for the following tests:

Adenovirus	Herpes	Rickettsia
Arbovirus testing	Influenza	Respiratory Syncytial virus (RSV)
Babesia	Lymphocytic choriomeningitis virus (LCM)	Rubella
Campylobacter	Legionella	Salmonella
Chikungunya	Lyme Disease	Shigella
Cytomegalovirus (CMV)	Measles	St. Louis Encephalitis
Dengue Fever	Mumps	Syphilis
E. coli	<i>Mycoplasma pneumoniae</i>	Vaccinia virus
Eastern Equine Encephalitis	Parainfluenza	Varicella zoster
Enterovirus	Parasitology serology	Vibrio
Ehrlichia	Pertussis	West Nile Virus
Hantavirus	Q Fever	Yellow Fever